THANJAVUR MEDICAL COLLEGE

DEPARTMENT OF PSYCHIATRY

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DIPLOMA IN PSYCHOLOGICAL MEDICINE

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Done by

Dr.M.SRIDHAR

Department of Psychiatry, Thanjavur Medical College,

Thanjavur.

CERTIFICATE

This is to certify that this "**PSYCHIATRIC CASE RECORD"** is a bonafide record of the work done by **Dr.M.SRIDHAR** under my supervision and guidance in the **DEPARTMENT OF PSYCHIATRY** at Thanjavur Medical College. Thanjavur during the period of his post graduate diploma study from **JUNE 2010 to APRIL 2012** for the partial fulfillment of **DIPLOMA IN PSYCHOLOGICAL MEDICINE.**

Professor and Head of the Department,
Department of Psychiatry
Thanjavur Medical College,
Thanjavur - 613 004.

The Dean,
Thanjavur Medical College,
Thanjavur - 613 004.

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CONTENTS

BIPOLAR DISORDER - MANIA

BIPOLAR DISORDER-MANIA WITH PSYCHOTIC FEATURES

Mr. Chandrasekar age 23/M belonging to low socio-economic status has been brought to the hospital by his father & relative for the following.

Complaints

- Excessive talk
- Not staying in one place
- Claiming himself high
- Dancing & singing .
- Abusive / assaultive
- Inadequate food intake
- Decreased Sleep X for one month duration
- Acute onset ,progressive coarse ,III rd episode

HISTORY OF PRESENT ILLNESS

Patient was apparently normal one-month back, Then all of a sudden he developed sleep disturbances –mainly difficult in initiation of sleep. He also started abusing his family members for unwanted things. Subsequently, he started talking excessively and irritable. Sometimes he sings film songs and dances.

He used to say that God Supreme exists in himself and so he has all the powers of Almighty. With that superior power he says that he can solve all the problems in this world. He also says that he has invented herbs to keep people young.

For the past one week, he talks excessively without having an hour of sleep & wanders here and there & found excessively smoking .He becomes excessively spiritual and goes to near by villages for offering prayers to God. He takes only a little food everyday and he is very much keen in personal cleanliness .

PAST HISTORY

- 1st Episode –During 2003 –manic episode –treated with drugs & 3 ECT's- @ our hospital, treated with mood stabilizers and anti psychotics.
- 2nd Episode –During 2008—manic episode –treated with drugs and 3 ECT's- @ our hospital ,treated with mood stabilizers and anti psychotics
- 3rd Episode –current episode
- No history of previous psychiatry illness
- No history of hypertension ,diabetes mellitus, bronchial asthma, CAHD
- No history of head injury , epilepsy, suicide ,absconding

FAMILY HISTORY

Father	-	Alive of 55 years, healthy.
Mother	-	50 years old alive and healthy.
Siblings	-	Patient is second in order of birth, and he has an elder brother.

No family history suggestive of mental illness, suicide, epilepsy or alcoholism.

PERSONAL HISTORY

- He studied upto 9th STD-Working as a building labor –past 5 yrs
- H/O frequent job changing present
- History of smoking present for the past 3 yrs, 5- 10 cigarettes /day

PREMORBID PERSONALITY

Extroverted personality.

Social Relationship :

He was reported to be sociable, had many friends. Quite helpful to others and participated in family and social get-together.

Intellectual Activities :

He used to read Tamil newspapers and magazines & watching TV

No other significant intellectual activities.

Interpersonal Relationship :

Satisfactory, no neurotic traits.

Mood :

Reported to be always cheerful and becomes sensitive and short tempered to others comments. He will not have the same emotional state for quite long time.

Character :

Sociable, sensitive short-tempered individual, quiet interested in taking up responsibility.

General examination :

Conscious, oriented , moderately built & nourished , not anemic, not jaundiced.

Pulse	-	78/mt
BP	-	120/70 mmhg
CVS / RS/ ABDOMEN	-	normal

MENTAL STATUS EXAMINATION

Patient is moderately built, moderately nourished, dressed appropriately and, conscious, alert and ambulant, eye-to-eye contact present, and rapport could be established easily- Psychomotor activity is increased. Talking in a flaboyant manner

SPEECH

He talks spontaneously much faster without any hesitation in loud tone with pressure of speech. He answered relevantly, & coherently

MOOD

- Subjectively he says that he is happy.
- Objectively he is elated,
- lability present, reactive mood
- inappropriate to situation,

THOUGHT

There is no formal thought disturbances

Stream -- Flight of ideas-present

Content -- Grandiose Delusions present

He says that he has got God Power

PERCEPTIVE DISTURBANCE

None.

HIGHER MENTAL FUNCTIONS :

ORIENTATION

Well oriented to time / place / persons.

MEMORY

Immediate, Short term and Long term are intact.

ATTENTION AND CONCENTRATION

Attention could be aroused easily but concentration was poor.

He is distracted easily by external stimuli.

He could do serial subtraction — 20 minus 1,

But he committed mistake while subtracting 7 serially from 100.

General Fund Intelligence	:	Intact
Abstraction and Judgement	:	Impaired
Insight	:	ABSENT Grade 1

DIAGNOSTIC FORMULATION

Mr.CHANDRASEKAR 23 yrs/M brought to the hospital by his father with complaints of disturbed sleep, abusive, assaultive, singing songs, dancing excess talk, inflated self esteem ,decreased food intake, wandering

for the past one month. Acute onset –progressive course –3rd episode. There was no precipitating factor. Premorbidly he is sociable, well adjusted individual with frequent change in job.

On Mental Status Examination, he has excess talk, grandiose delusion, mood is elated with accelerated psychomotor activity and impaired attention & concentration with absent insight about his illness

With the above clinical history and examination the diagnosis of **F 30.1 - BIPOLAR AFFECTIVE DISORDER CURRENT EPISODE MANIA WITH PSYCHOTIC FEATURE** was made.

PSYCHOMETRY

Psychometry was done to confirm the provisional diagnosis and to rule out Schizophrenia.

BEHAVIOURAL OBSERVATION

He was –co operative, attention could be aroused, but concentration was poor. Distractibility was present. Comprehension adequate. He was easily irritable.

TEST FINDINGS

1. **Eysenck's Personality Questionnaire :**

   He scored as follows

Extroversion	-	15
Psychoticism	-	12
Neuroticism	-	10
Lie scale	-	4

   He scored high on extroversion and psychoticism.

2. **Multiphasic Personality Questionnaire :**

   He scored as follows :

Anxiety	-	10
Hysteria	-	4
Depression	-	4
Mania	-	8
Schizophrenia	-	3
Paranoia	-	4
Psychopathy	-	10
K Scale	-	3

   He scored high on mania and anxiety

3. Sentence Completion Test :

On sentence completion test patient attitude towards interpersonal relationship and family were disturbed. His self concept was disturbed with grandiose and optimistic ideas.

4. Rorschach Ink blot test :

Mental productivity	-	above average – 50 responses (Normal 10-20)
Mentation	-	rapid - 15 seconds (Normal 30 sec)
Personality	-	extrovert
Psychotic features	-	present

5. Thematic Apperception Test :

Nature of stories	-	elaborate, but descriptive
Identification	-	fair
Pre-dominant conflict	-	self
Pre-dominant emotion	-	irritability, expansiveness
Associative disturbances	-	Present

6. **Proverb Test** :

   He was able to give concrete and abstract meaning for 2 out of 4 familiar proverbs.

7. **Draw a person and house – Three – Person Test :**

   Drawings were expansive and macro – graphic.

   No evidence of body – image disturbances or penetration.

8. **Object sorting Test :**

   No evidence of over inclusive thinking

9. **Repertory Grid Test :**

   Construct formation - intact

10. **Mania Rating Scale** :

    He was found to have grandiose ideas, irritable during interview.

    The rate and amount of speech was increased and his behavior was demanding and threatening.

    But he was markedly active, distractible and argumentative.

SUMMARY OF FINDINGS :

Patient was co-operative but distractible. He was found to be an extratensive individual. Projective tests revealed evidence of psychosis of affective type. Abstract thinking intact. No evidence of over inclusive thinking. Construct formation adequate.

DISCUSSION & MANAGEMENT

The provisional diagnosis of Bipolar disorder -Mania was confirmed with psychometry. There was no evidence of Schizophrenia.

In view of his restlessness he was admitted and treated with antipsychotic drugs.

T.CARBAMAZEPINE 200mg	1BD
T..CHLORPROMAZINE 100 mg.	1BD
T.RISPERIDONE 2mg	1BD
T.TRIHEXY PHENIDYL 2 mg	1BD
T.DIAZEPAM 5mg	1BD

Along with the drugs he received five electro – convulsive therapy, he showed good improvement and was discharged with advice to attend psychiatric out patient department regularly.

PARANOID

SCHIZOPHRENIA

PARANOID SCHIZOPHRENIA

Mrs.Thenmozhi, a married female aged 29 years was brought to our department by her husband, for the following complaints.

- Sleep disturbances
- Irrelevant speech
- Talking to self / muttering to herself
- Smiling to self
- Hearing voices/ suspicious ideas
- Food refusal
- Assaultive/ abusive behavior
- Wandering behavior
- Neglecting personal hygiene

Duration : 8 months

Onset : Gradual and progressively deteriorating

HISTORY OF PRESENTING ILLNESS

She was apparently normal 8 months back, then she developed sleep disturbances in the form of difficult in falling asleep. She was found talking & smiling to herself at night & day with mirror gazing. She started saying that her neighbour & relatives are planning to kill herself by poisoning.

In this context she had frequent quarrels with them and she refused to take food prepared by her mother in law.

She left the home at night without informing any one and started wandering in the road side near her home. She was complaining that she hears voices as if her neighbour & relatives were talking about her among themselves

She was not doing house hold activities for past 6 months and she was not taking care of her child. Her personal hygiene was very much deteriorated slowly as she used to take bath & brush, only if she was asked to do so. She started abusing & assaulting the strangers and family members.

PAST HISTORY

- No history of previous psychiatry illness
- No history of hypertension ,diabetes mellitus, bronchial asthma , CAHD
- No history of head injury, epilepsy .

FAMILY HISTORY

Non – consanguinous parents.

Father	:	Alive , aged 60 years, is an agricultural labour
Mother	:	Alive, aged 54 looks after house hold works.
Siblings	:	First sibling is a male aged 32 years. he is married and has a female child
Second	:	Patient
Third	:	is a female aged 22, married and lives separately with her husband

- There is a positive family history of psychiatric illness in her maternal grandmother – psychotic illness with long duration & deteriorating course
- No history of drug abuse , suicide or absconding from her family.
- Their family belongs to low socio economic status. Family members are well adjustable to each other.

PERSONAL HISTORY

INFANCY AND CHILDHOOD

She was a full term child, delivered normally at home. She was breast fed. Early development milestones were normal. There were no neurotic traits.

EDUCATIONAL HISTORY

She joined school at the age of 5 years. As she failed in 10th STD, she discontinued her studies. She was average in her studies. At school, she never participated in any extra – curricular activities.

Menstrual history

Attained menarche by 14 yrs – regular periods 4/30

No history of any pre menstrual dysphoria

SEXUAL AND MARITAL HISTORY

She is married to Mariappan 3 yrs before, having one male child of two years age. No history of any pre-marital sexual relations.

OCCUPATIONAL HISTORY

After discontinuing her studies, she worked in a tailor shop for 3 years. As she was not able to adjust with the owner, she left the job. A year

later she started working in a grocery shop and left the shop and unemployed for the past 2 years before her marriage.

PRE MORBID PERSONALITY

She was reserved, shy and sensitive. She kept herself aloof and had very few friends. She was not efficient & adjustable in her works.

General examination :

Conscious, oriented , moderately built & nourished , anemic, not jaundiced.

Pulse	-	78/mt
BP	-	110/70 mmhg
CVS / RS/ ABDOMEN	-	normal

MENTAL STATUS EXAMINATION

GENERAL APPEARNCE AND BEHAVIOUR

She is conscious, alert ambulant, shabbily dressed ,preoccupied.

Makes gestures, mutters to herself, not cooperating .

Eye contact absent. Rapport not fully established.

Not in touch with surrounding

Psychomotor activity increased

SPEECH

- Rate and quantum of speech increased
- Her talk irrelevant but coherent. At times she mutters,
- Tone and speed normal. Reaction time normal

MOOD

- She express happiness subjectively.
- Objectively her mood was irritable.
- Reactive mood
- Range of emotion - normal
- Appropriate to surrounding,

THOUGHT

- Form and stream of thought normal
- She says that her neighbours are talking about herself and they are trying to kill her by poisoning-**delusions of reference & delusions of persecution.**
- She says that her half of the body are not functioning properly and are being controlled by a foreign force – **Somatic passivity present**
- She states that her thoughts are made known to others through a wireless. **Thought Broadcasting.**

PERCEPTION

She had auditory hallucinations of known male and female voices scolding and commenting about herself in third person

COGNITION

ORIENTATION

She is oriented to place, person and time.

MEMORY

Her immediate ,recent & remote memories were intact.

ATTENTION AND CONCENTRATION

Her attention could be aroused but not sustained. she is distractable and her concentration is fair.

GENERAL FUND OF INFORMATION

General information is average.

INTELLIGENCE	:	Average
ABSTRACT THINKING	:	concrete reasoning present ,
INSIGHT	:	Lacks insight Grade 1
JUDGEMENT	:	Impaired

DIAGNOSTIC FORMULATION

A 29 years old Mrs.Thenmozhi, brought with the complaints of sleeplessness., talking to self, anger outbursts, smiling to self, food refusal, wandering tendency and neglecting personal hygiene.

On examination, patient was found to be preoccupied, making gestures, talking irrelevantly. She has irritable affect, ideas of references, ideas of persecution , somatic passivity feeling, thought broadcast and auditory hallucinations. Patient lacks insight and her judgement impaired.

Based on history, presenting symptoms, clinical findings the patient is diagnosed as a case of **F 20.0 SCHIZOPHRENIA – PARANOID TYPE.**

PSYCHOMETRY

Psychometry was done in three sittings. She was co-operative concentration and comprehension were adequate irrelevant talk noticed frequently.

Psychometry was done to assess and investigate the following areas.

1. Personality and interpersonal areas
2. Thought process
3. Concept formation

TEST ADMINISTERED

I. QUESTIONNAIRES

a. Eysenck Personality Questionnaire

b. Multiphasic Personality Questionnaire

II. PROJECTIVE TESTS

a. Rorschach Ink – Blot Test

b. Thematic Apperception Test

c. Drawings

III.THOUGHT PROCESS, CONCEPT FORMATION AND TEST OF CONSTRUCT FORMATION

a. Proverb test

b. Object sorting test

c. Repertory Grid Technique

TEST FINDINGS

I.QUESTIONNAIRES

a. **Eysenck Personality Questionnaire**

He scored as follows :

Extraversion	:	6
Neuroticism	:	7
Psychotism	:	12
Lie Scale	:	7

Patient scored high on psychotism, introversion and lie scale.

b. **Multiphasic Personality Questionnaire**

Patient's score is as follows :

Anxiety	-	8
Mania	-	3
Schizophrenia	-	11
Hysteria	-	2
Depression	-	2
Paranoid	-	9
Psychopathic deviation	-	10
K-Scale	-	3

Patient scored significantly high on schizophrenia and paranoid scales.

II.PROJECTIVE TEST

a. Rorschach Ink – blot test

Mental Productivity	:	Average (12 responses)
Mentation	:	Adequate (65 secs)
Personality	:	Interotensive
Psychotic features	:	Present

(Unusual detailed responses, "PO" responses And contamination)

b. Thematic apperception test

Nature of stories	:	Descriptive
Identification	:	Poor
Significant Conflicts	:	Nil
Predominant theme	:	absent
Associative disturbances (loosening of association)	:	Present

c. Drawings

Drawings were primitive with body image disturbance and penetration

III. THOUGHT PROCESS, CONCEPT FORMATION AND CONSTRUCT FORMATION

a. PROVERB TEST

Total number of proverbs – 5. Patient gave concrete and near abstract responses to only 2 proverbs.

b. OBJECTIVE SORTING TEST

Evidence of over inclusive thinking present.

c. REPERTORY GRID TECHNIQUE

Total constructs given is 8. There is evidence of impairment in construct formation.

SUMMARY OF PSYCHOMETRY

Patient was co-operative& irritable at times .she was found to be introverted individual with elevated scores on schizopherenia and paranoid scales. Her abstract thinking was impaired. Evidence of over inclusive thinking present. Projective test reveal definite evidence of schizophrenic psychosis.

DISCUSSION AND MANAGEMENT:

The provisional diagnosis is confirmed with psychometry. It also revealed marked disturbance in thinking process, concept and construct formation .

She was admitted and treated with-

T.CHLORPROMAZINE 100mg	1TID
T.RISPERIDONE 2mg	1BD
T.TRIHEXY 2mg	1BD
T.DIAZEPAM 5mg	1HS

Along with above drugs she was given 5 ECT's in a period of 20 days of her hospital stay. Patient's symptoms were controlled with above treatment and she was discharged and advised to attend the OPD to get drugs regularly and to make regular review once in a month.

GENERALISED ANXIETY DISORDER

F.41.1. GENERALISED ANXIETY DISORDER

Mr. Arulmurugan aged 30 years, a graduate from a middle class family, has been brought to the hospital by his sister & mother with the following complaints.

- Shaking of hand
- Palpitation & chest discomfort
- Difficulty in breathing & shortness of breath
- Dryness of mouth & excessive sweating
- Numbness, tiredness & muscle aches
- Light headedness
- Giddiness & weakness
- Bad dreams---night mares
- Fear about his future
- Excessive worrying for the past 8 months.

HISTORY OF PRESENT ILLNESS

Six months back he was apparently normal. He is working as a system analyst in a private bank . He had once, made a mistake in his bank work for which he was given charges by his employer, followed this event he

becomes very tense and afraid whenever his boss called him. He is very cautious that he should not commit any mistakes. Even though he is not doing so, he fears that he may commit some mistake in his work. At that moment he develops palpitation, giddiness, breathlessness, excessive sweating over palms and soles. Slowly these symptoms present through out the day even when he was not in his office , and he could not control his fearfulness. For the past 6 months he didn't sleep well. His sleep is disturbed by bad dreams.

PAST HISTORY

- No previous history of similar episode
- No history of head injury.
- No history of loss of conscious/ syncope
- No history of suicide,
- No history of Epilepsy.
- No history suggestive of repeated ritualistic activities
- No history hypertension ,diabetes ,asthma ,CAHD

FAMILY HISTORY

Father - 55 Years old alive and healthy

Working as head clerk in a Govt. bank.

Mother - 51 Years old alive and healthy, a Housewife.

Both of them are affectionate towards him.

Siblings - He was the second child in order of birth. He has

An elder sister. His sister is healthy and married ,

working in a private company

No family history of mental illness or suicide or alcoholism or epilepsy

PERSONAL HISTORY

Delivered as a full term normal delivery.

Hospital delivery.

Cried well immediately after birth.

No history suggestive of birth asphyxia or cyanosis.

All developmental milestones were normal.

No history of parental deprivation or separation.

He was living with his parents. He has limited friends.

EDUCATIONAL HISTORY

He started schooling at the age of 4 years. He completed his school educational at Thanjavur. He did his graduation from the same city. He was an average student and he had no extra curricular activities.

OCCUPATIONAL HISTORY

He completed graduation in computer science 12 years before, since then he is working as a system analyst in a private company. .

SEXUAL AND MARITAL HISTORY

He attained the sexual knowledge at the age of 16 years. No history of premarital sexual relationship. He is very anxious while thinking about his marriage and his sexual life.

PREMORBID PERSONALITY

SOCIAL RELATIONS :

He prefers to be alone. He is less social and much reserved. He becomes anxious and nervous on meeting people who are all above his status or opposite sex.

INTELLECTUAL ACTIVITIES :

He shows more interest in reading story books. He like all aspects of stories.

MOOD :

Said to be very tense anxious with pessimistic attitudes. Ability to experience pleasure is limited. Not easily satisfied about his performance and does not give credit to self.

CHARACTER :

Reserved, hard working and sincere individual, preferred to stay alone. He is sensitive to comments and criticism, quite afraid of personality, self – absorption in fantasy life.

GENERAL EXAMINATION

Moderately bult, moderately nourished, not anaemic, not jaundiced, no localized or generalized lymphadenopathy.No neck swelling. Excessively sweating present.

BP	:	120 / 80 mm of Hg
Pulse	:	92 / mt regular

SYSTEMIC EXAMINATION

Cardiovascular System	:	S1,S2 Heard, no murmur.
Respiratory System	:	Trachea in mid line.
		Respiratory rate – 18/mt
		Normal vesicular breath sounds
		heard no added sounds

Abdomen	:	Soft, no organomegaly no free fluid.
Central nervous System	:	Higher functions sensory, Motor, Spinal system are normal.

MENTAL STATUS EXAMINATION

General Appearance and Behaviour :

Patient is moderately built, moderately nourished, adequately dressed, hair is well groomed hair .He took the seat offered , sat at its edge . he has good eye-to-eye contact, and rapport is established without any difficulty. His psychomotor activity is adequate except mild tremor of both hands, & prespirating

SPEECH :

- Speech is in normal tone, relevant and coherent.
- Content of all talk is about sexual fear and fear of committing mistakes & unexplained worries.

MOOD :

- Subjectively he feels sad and fearful & expresses palpitation
- Objectively he is anxious and depressed.
- Reactive with normal range of emotion
- Appropriate to the surrounding

Thought : No formal thought disorder

Perception : No perceptive disturbances.

HIGHER MENTAL FUNCTIONS

Orientation : He is well oriented to Time, Place and person

Memory : Immediate, short-tem and long-term memory are intact.

Attention and Concentration : Attention can be aroused easily and sustained for a long time

General Fund of Information

Intelligence : normal

Judgement : good

Insight : **present Grade 5**

DIAGNOSTIC FORMULATION

Mr.Arulmurugan aged 30 years unmarried male with complaints of palpitation, breathlessness, giddiness, sweating over palms for the past 6 months duration, which is sudden in onset and precipitated by stress at his working place.

Eventually he has symptoms present through out the day & diminished only when taking rest. Premorbidly he was a reserved and tensed individual.

On MSE he is co-operative and expressed depressive ideas. His affect is anxious. The above clinical history and MSE indicate the diagnosis of **GENERALIZED ANXIETY DISORDER.**

PSYCHOMETRY

Psychometry was done to confirm the provisional diagnosis to study the personality, to explore the motivation and interpersonal areas.

BEHAVIOURAL OBSERVATION

He is co-operative , quite anxious, concentration and comprehension are adequate.

TEST FINDINGS

1. **Eysenk's Personality Questionnaire**

   He scored as follows :

   Extraversion : 14

   Neuroticism : 13

   Lie Scale : 1

   He Scored high on neuroticism and extraversion.

2. Multiphasic Personality Questionnaire

He scored as follows :

Anxiety	-	15
Depression	-	8
Mania	-	3
Paranoia	-	2
Schizophrenia	-	3
Hysteria	-	3
Psychopathy	-	7
K-Scale	-	3

He scored high on anxiety and depression scales.

3. Sentence – Completion Test

Patient scored on this test is given below :

Attitude towards family	:	Intact
Attitude towards sex	:	Disturbed
Attitude towards marriage	:	Disturbed
Attitude towards self	:	Disturbed
Attitude towards interpersonal relationship	:	Disturbed

Attitude towards Superiors and colleagues	:	Disturbed
Attitude towards Past, Present , Future	:	Disturbed

He has marked interpersonal problems with family, sex, marriage, self and future.

4. Rorschach Ink – Blot Test

Mental Productivity	:	Average with 13 responses (Normal 10)
Mentation	:	Normal with 35 secs. (Normal 30)
Personality	:	Introtensive individual
Psychotic features	:	Absent
Neurotic construction	:	Present

(rejections, high animal and anatomical responses, color shock)

5. Thematic Appercepation Test

Nature of stories	:	Rarely productive
Identification	:	Fair
Signification conflict	:	Self, interpersonal and future

Predominant emotion	:	Depression with anxiety
Figures perceived	:	Hostile and threatening
Figures reacted with	:	Depression, anxiety and pessimism.

6. **Proverb Test**

   His abstract thinking was intact.

7. **Draw a person, and a House Tree Person (DAP HTP)**

   No evidence of body image disturbances, and penetration

8. **Objects Sorting Test**

   No evidence of over inclusive thinking

SUMMARY OF TEST FINDINGS

H e was co-operative, and anxious. He was found to be an introtensive individual with neurotic constriction, predominantly anxiety and depression. His attitude towards sex, marriage, self and interpersonal relationship are disturbed. No evidence of psychosis.

IMPRESSION : F 41.1. "GENERALIZED ANXIETY DISORDER"

DISCUSSION AND MANAGEMENT

Provisional diagnosis of GAD was confirmed by psychometry.

The areas of conflict as seen from the psychological assessment appears to be around *self, sex. Women, Marriage, with inter- personal relations and future*.

As the patient was very tense and anxious minor tranquilizers were given before subjecting to psychotherapy and behavior therapy.

C.FLUOXETINE 20 MG 1---0---0

T.DIAZEPAM 5MG. 1—0---2

T.PROPRANOLAL 40MG 1/2 --0---1/2 –

continued for 2 weeks , he felt very much better.

On course of treatment, He was taught to do cognitive oriented. **"JACOBSON'S RELAXATION THERAPY"** for his anxiety symptoms and behavior oriented, **"SYSTEMATIC DE-SENSITISATION PROCEDURE"** for the specific fear related to authoritative figure was started.

He was advised to attend the therapy session regularly.

RECURRENT

DEPRESSIVE DISORDER

F33.3 RECURRENT DEPRESSIVE DISORDER,

CURRENT EPISODE SEVERE WITH PSYCHOTIC SYMPTOMS

Mrs.Faritha Begum 46 years old female studied up to 8th standard, married, Muslim, middle socioeconomic status brought by her husband with the following Complaints.

- Feeling of sadness / crying spells
- Loss of interest in pleasurable activities
- Sleep disturbances, easy fatigability
- Not doing domestic work
- Suicidal attempt
- Hopelessness / helplessness
- Suspicious ideas
- Hearing voices
- Poor Self care
- For the past 2 months

4th episode, insidious onset,progressive course

HISTORY OF PRESENT ILLNESS

Patient was apparently alright 2 months back. Then she developed sleep disturbances particularly early morning awakening , she use to wake up by 3.00 am and use to brood about herself and started crying . She was not doing her domestic work as before, as she felt excess tiredness and use to take frequent rests. She developed poor communication. She had lost her interest in pleasurable activities and was not interested in watching TV, and attending family gatherings. She stayed aloof most of the time & calm, quiet and withdrawn. She was expressing her helplessness and hopelessness about the future.

She started to have decline in maintaining self care. 15 days back, she frequently expressed suicidal ideas and she had attempted suicide by hanging herself and was rescued by neighbours.

5 days back, she started talking in an irrelevant manner. She was smiling to self. She was assaulting her family members. She was suspicious that her neighbour had done black magic on her and also saying that people are talking about her. She reported hearing the voice of her neighbour scolding and threatening her.

PAST HISTORY

- History of similar illness in the past present
- 1st episode following her third child birth in 1999 –depressive episode with suicidal ideas ,treated at Nagai GH with drugs and ECT
- 2ND episode during 2001 –Depressive episode treated with drugs and ECT at TMCH
- 3RD episode during 2005—depressive episode- treated by private psychiatrist @ Thanjavur with drugs only
- 4th episode –current episode
- No history of major medical illness
- No history of head injury / fits
- No history of substance abuse
- No history o hypomania or manic episode

FAMILY HISTORY

Father - expired due to CAHD

Mother - alive, 67 years old, known asthmatic

She is born of non consanguineous marriage. She is the third child of the family.

Siblings - the patient has 2 elder brother & 1 younger sister who are healthy and married

Family history of suicide in her maternal aunt present.

No family history of absconding or alcoholism.

PERSONAL HISTORY

- Delivered as a full term normal hospital delivery
- Cried well after birth
- No history suggestive of birth asphyxia or cyanosis.
- All developmental milestones were normal.
- Her home atmosphere during infancy and childhood was good.
- No history of parental separation and deprivation

EDUCATIONAL HISTORY

- She started schooling at or around the age of six years.
- She studied up to 8^{th} standard.
- She was average student.

OCCUPATIONAL HISTORY

- She was not working .

MENSTRUAL HISTORY

- Attained menarche by 15 years of age
- Regular cycles; 3/30 days
- LMP – 20 days back

MARITAL HISTORY

- Married to Mariam pitchai 25 years ago as a second wife
- History of frequent marital disharmony present
- Having three children 1 son & 2 daughters
- Elder son died of an accident during 1998

PREMORBID PERSONALITY

- Self absorbed
- Concerned with her own thoughts
- Socially not adjustable
- Not making friends easily
- Poor interpersonal relationships

GENERAL EXAMINATION

Conscious, oriented, well built & well nourished, not anemic, not jaundiced.

BP - 140/90 mm hg

Pulse – 84 beats/min

CVS, RS, P/A – Normal

MENTAL STATUS EXAMINATION

- Patient is alert, ambulant, dressed appropriately with kempt hair.
- Gaze contact made and maintained.
- Normally cooperating .
- Rapport established.
- Psychomotor activity – decreased.
- Crying spells present while talking about her elder son and marital life

SPEECH

- Rate and quantum of speech decreased.
- Tone was low.
- Reaction time was increased.
- The speech was relevant and coherent

THOUGHT

- Form and Stream of thought were normal.
- She expressed low mood
- Anhedonia present
- She had delusion of persecution and delusion of reference.
- She had suicidal ideas.
- Ideas of hopelessness present.

MOOD

- Subjectively reports feeling sad.
- Objectively she was depressed.
- At times she was crying
- Mood is reactive to thought content.

PERCEPTION

- Had auditory hallucinations.
- Voices of her neighbour scolding and threatening her

COGNITION

Orientation

- Oriented to time, place & person.

Attention & Concentration

- Aroused and not sustained.

Memory

- Immediate recall, recent memory and remote memory were intact.

Abstract thinking

- Concrete reasoning present in proverb testing.

Intelligence

- Normal

Judgement

- Normal

Insight

- Patient lacks insight. / Grade 3

DIAGNOSTIC FORMULATION

A 46 year old female brought by her husband with complaints of feeling of sadness, loss of interest, sleep disturbances, suicidal attempt, irrelevant speech, suspicious ideas, hearing voices, poor self care for the past 2 months.

History of three depressive episodes present with positive family history of suicide.

On general examination the patient was normal. On MSE, the patient had decreased speech, low mood ,helplessness ideas, ideas of persecution, ideas of reference and suicidal ideas & suicidal gestures, with auditory hallucinations, with depressed mood, with nearly adequate cognition.

Based on history and mental status examination, the provisional diagnosis is

F33.3 RECURRENT DEPRESSIVE DISORDER, CURRENT EPISODE SEVERE WITH PSYCHOTIC SYMPTOMS .

PSYCHOMETRY

Psychometry was done to confirm the provisional diagnosis of severe depression with psychotic features and to investigate the following areas.

1. Personality
2. Thought process
3. Concept formation

BEHAVIOURAL OBSERVATION

The patient was tested on four occasions. She was cooperative for testing. Her comprehension was average and performed the tests with some difficulty.

TEST FINDINGS

1. **EYSENCK PERSONALITY QUESTIONNAIRE**

   The patient has got ambivert type of person with significant psychotism scores(14) and her neurotic scores were not significant.

   Her lie score was also not significant.

2. MULTIPHASIC PERSONALITY QUESTIONNAIRE

The patient scored as follows

Anxiety	-	10
Hysteria	-	3
Depression	-	1 4
Mania	-	2
Schizophrenia	-	2
Paranoia	-	7
Psychopathy	-	8
K scale	-	4

She scored high on depression scale.

3. RORSCHACH'S INK BLOT TEST

Her responses show that she has got significant depressive ideation in her thought process. Presence of P and W response show that her orientation with reality is intact. Overall Rorschach responses suggest depressive features with significant psychotic thought process.

4. THEMATIC APPERCEPTION TEST

Nature of stories	:	Descriptive
Identification	:	Poor

Significant conflict	:	Nil
Predominant theme	:	Absent
Associative disturbances	:	Absent

5. HAMILTON DEPRESSION RATING SCALE

In Hamilton depression rating scale, she has got 29 which is a severe level of depression of which depressed mood, suicide, early insomnia, retardation, work and activities scores are significant.

6. PROVERB TEST

Total number of proverbs – 5. Patient gave concrete and near abstract responses to only 2 proverbs

SUMMARY OF PSYCHOMETRY

The patient was cooperative. She was found to be ambivert individual with elevated scores on depression scales. Projective test reveal definitive evidence of depression with psychotic thought process. She has significant score on Hamilton Depression rating scale.

Above psychometric findings definitely indicate evidence of

F33.3 RECURRENT DEPRESSIVE DISORDER, CURRENT EPISODE SEVERE WITH PSYCHOTIC SYMPTOMS

DISCUSSION AND MANAGEMENT

The provisional diagnosis was confirmed by psychometry. In addition psychometric finding revealed depressive thought process with significant psychotic features.

The patient was admitted and treated as inpatient. She received the following treatment.

CAP. FLUOXETINE 20 MG	1---0---0
TAB. RISPERIDONE 2MG	1---0---1
TAB. CHOLORPROMAZINE 100MG	1---0---1
TAB. BENZHEXOL 2MG	1---1---0
TAB .DIAZEPAM 5MG	0---0---1

In addition to drug therapy she was given 5 ECTs in a period of 25 days of her hospital stay . Psychosocial treatment such as psychotherapy and behavioural modification were also tried.

Patient's symptoms were controlled with above treatment and she was discharged with advice to attend psychiatric OP regularly and to take drugs regularly.

ORGANIC BRAIN SYNDROME - DEMENTIA

ORGANIC BRAIN SYNDROME – F.00.1 - DEMENTIA

Mr.Punniamurthy aged 72 years old christian male belonging to middle socio economic status has been brought to hospital by his wife & son for the following complaints:

- Forgetfulness,
- Aggressive behavior,
- Assaulting his wife,
- Restlessness ,
- Sleeplessness / fearfulness,
- Saying that people are talking about himself,
- Wandering out of home & not returning home by himself,
- Hearing voices,
- All since 10 months duration.
- First episode slowly progressive & deteriorating course

HISTORY OF PRESENT ILLNESS

Ten -months back he was apparently alright. Then his relatives noticed himself frequently misplaces things inside his home .Then he started behaving aggressively. He was beating his wife without reason. He was roaming here and there, running out of home and wandering aimlessly. He was not able to come back home when he goes out. He was brought back to home by his relatives.

Slowly he developed fearfulness and tremulousness while he was staying alone.

He also started saying that his family members & neighbours were talking about himself ,in this context he would make frequent quarrels with them. He also started hearing voices of known male voices abusing himself in third person

He sleeps for few hour only. He is passing urine and motion inside the house. He is asking about his brother and mother-in-law who were expired long back. He behaves abnormally such as pouring water in the plate while eating. And his relatives found the symptoms were worsened by evening.

All these symptoms started insidiously, increased in severity through time and attained the present state.

No history of loss of appetite / crying spells / suicidal tendencies / convulsions / fever / head injury.

PAST HISTORY

- No similar episode in past.
- No history of head injury.
- No history of diabetes / hypertension / stroke / TB
- No history of any drug abuse.

FAMILY HISTORY

Father - expired at the age of 68 years.

Mother - expired at the age of 75 years.

Siblings - patient is first in order of birth. He has two younger sisters and a younger brother

Both were healthy and doing well.

No family history of mental illness, suicide, epilepsy or alcoholism.

PERSONAL HISTORY

He was born of non-consanguineous marriage.

Delivered as a full term normal home delivery.

Cried well after birth.

No history suggestive of birth asphyxia or cyanosis.

All developmental milestones were said to be normal.

He studied upto 6 th STD .

He takes alcohol from the age of 20 years approximately 180ml of whisky weekly twice till the age of 60 years. After that he was completely abstained from it.

He is a regular user of betel nut & tobacco, and a smoker 5 to 10 beedies /day.

SEXUAL AND MARITAL HISTORY

He got married at the age of 22 years. It was consanguineous, arranged marriage. No history of extra marital relationship. He has two daughters and a son, two daughters were married and he lived along with his son as a joint family

PREMORBID PERSONALITY

Extroverted personality.

He reported to be social, had many friends. He was quite helpful to others and participated in family functions and social get-together.

MOOD

He was reported to be cheerful & bright.

CHARACTER

He was sociable, talking care of needs for family members satisfactorily and maintaining smooth relations with other relatives. He was quite interested in taking up responsibility.

GENERAL EXAMINATIONS

Patient is moderately built nourished not anemic, not jaundiced, no lymphadenopathy

Pulse	-	84 per min.
BP	-	140/70 mm of Hg.
CVS, Rs, P/A	-	Normal
Fundus	-	Normal

Cranial nerves & spinal motor system normal

MENTAL STATUS EXAMINATION

GENERAL APPEARANCE

He dressed in an inappropriate manner with dirty shirt, hair is not combed. He is conscious and ambulating. His psychomotor activity is increased with marked agitation. He stares at other. Rapport is established with difficulty. He seems to be unaware of his problems

SPEECH.

He talks spontaneously and excessively, sometime monosyllables. He can understand the question. Sometime his speech become incoherent and irrelevant.

MOOD

- Subjectively he says that he is alright.
- Objectively his mood is labile.
- Range of emotion increased
- Emotional reactivity present
- Diurnal variation present

THOUGHT

Perseveration present / ideas of reference present / delusions of reference present.

PERCEPTION

Auditory hallucination present occasionally. Known male voices of commenting nature .

PRIMARY MENTAL FUNCTION:

Orientation

He is oriented to persons but not with time & place.

Memory

Immediate, short term and long term memory is impaired.

Attention and concentration

Attention - impaired

Concentration

Concentration---impaired

He could not do serial subtraction 100 - 7, 40 - 3 or 20 - 1.

General fund of Intelligence:

Patient is not much cooperative.

He was asked to name five cities he answered only one.

Judgment : Impaired

Insight : grade 1.Patient lacks insight. He is telling that he is not having any problem.

DIAGNOSTIC FORMULATION

Mr. Punniamurthy aged 72 years was brought by his wife and son with complaints of forgetfulness, aggressive behavior, sleeplessness, hearing voices, restlessness, &fearfulness, wandering out of home since 8 months duration which was gradual in onset & without precipitating factors. Premorbidly well adjusted sociable individual. On MSE he shows marked increase in psychomotor activities with spontaneous speech. His affect was labile and he lacks insight.

With above clinical history and examination a diagnosis of

ORGANIC BRAIN SYNDROME - DEMENTIA was made

PSYCHOMETRY

Psychometry was done primarily to confirm Organic brain syndrome-dementia Behavioral observation

He was not much cooperative and Psychomotor agitation present.

Concentration and comprehension: fair

TEST FINDINGS

1. **Knox cube imitation test:**

   He scored two on this test which indicated impaired concentration.

2. **Bender Gestalt Test:**

   He did the test with persuasion. His perceptual organization was impaired, gross evidence of organicity present.

3. **Wechsler's memory scale:**

   He scored as follows

Personal and current information	-	4
Orientation	-	3
Mental control	-	2
Digit backward	-	4
Logical memory	-	3
Visual reproduction	-	6
Associative learning	-	1
Total Score	**-**	**23**

Age correction	-	48
Corrected score	-	71
Mental quotient	-	63
Equivalent M.Q.	=	63 (normal 90) patient's memory

Functioning was definitely below average.

4. RAVEN'S PROGRESSIVE MATRICES:

His intellectual functioning was definitely below the average and his cooperation for the test was poor. He scored 10 for 5 set.

	(A – E)
A	----3
B	----1
C	-----1
D	----3
E	-----2
Total	10

5. Bhatia's short scale:

His intellectual functioning was found to be at a low average level. I.Q. 65

6. PIOTROWSKI'S SIGNS OF ORGANICITY

The test shows the following signs of organicity.

(a) "Colour naming" (colours are named by the subjects instead of forming more detailed interpretation of Rorschach.)

(b) Stereotypy

(c) Perseveration

(d) The patient recognizes that his response to the card is unsatisfactory but unable to withdraw the response or improve upon it / hesitancy.

7. PORTEUS MAZE TEST:

He didn't cooperative for this test.

8. RORSCHACH'S INK BLOT TEST:

Mental productivity	:	below average with 8 responses (Normal 10)
Mentation	:	Rapid 10 sec. (Normal 30)
Personality	:	Extratensive
Organicity feature	:	Present (Colour naming, stereotypy, Perseveration and Hesitancy)
Depressive features	:	Absent.

9. PROVERB TEST:

Patient could not give concrete meaning

10. B. T. R. TEST

He scores 5 indicating the evidence of dementia.

11. HAMILTON DEPRESSION RATING SCALE

Insomnia	-	1
Work and activities	-	1
Agitation	-	3

It indicates no evidence of depression.

12. CLOCK DRAWINING TEST

He could not even complete a single quarter..indicates his difficult orientation

13. MINI MENTAL STATE EXAMINATION –

He scored an average of 13-16 on two occasion after admission,

SUMMARY OF FINDINGS

Patient was not very cooperative. He showed Psychomotor agitation, perceptual organization impaired with gross evidence of organicity. His intellectual and memory functioning were below average. (I.Q. 65, M.Q. 63). Projective tests and rating scales revealed evidence of organicity, but showed no significant evidence of depression.

IMPRESSION

ORGANIC BRAIN SYNDROME

F.00.1 DEMENTIA IN ALZHEIMER'S DISEASE WITH LATE ONSET

DISSCUSSION AND MANAGEMENT

The provisional diagnosis of OBS – Dementia was confirmed by Psychometry. The differential diagnosis of depression was ruled out as there is no consistent evidence for depression.

He was admitted and subjected to routine investigation such as complete haemogram VDRL, Blood urea & sugar, serum creatinine & Chest x-ray with ECG. The investigations were non-contributory.

He was suggested to take CT –BRAIN and it revealed *diffuse cortical atrophic changes* , which further substantiated the diagnosis

Treatment

Supportive treatment

1 . Adequate nutrition

2 Adequate calm environment with aids to provide proper reorienting ques

Psychological Treatment

Supportive therapy & group therapy for family members

Pharmacological Treatment

He was started on

TAB. HALOPERIDOL 1.5MG 1BD

TAB. LORAZEPAM 5 MG 1 HS (SOS)

Counselling was given to family members about the prognosis of the illness .

Advice to attend Psychiatry O.P. regularly is given.